

Kentucky Crime Victims Compensation Board
130 Brighton Park Blvd., Frankfort, KY 40601

HIV POST-EXPOSURE *THIRD* FOLLOW-UP EXAM / TREATMENT BILLING FORM

Patient Name: _____

To be entered by CVCB

CVCB case # _____

Attention authorized medical personnel administering treatment or service: check box for each service rendered.
Fax completed forms and itemized bills to (502) 573-4817. For information, call: (502) 573-2290 / (800) 469-2120.

Third / Final Follow-up Exam (Day 28)		
<i>Category</i>	<i>Cost Reimbursement</i>	<i>Rendered</i>
Exam	\$50	
Labs (CBC, CMP)	\$75	
I certify completion of the above checked categories.		
Printed Name _____		Signature _____
Facility (Payee) Address _____	Phone # _____	Federal ID # _____

KRS 346.200(9) No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist or health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to KY Crime Victim Compensation Board for billing purposes.

Patient Signature

Date